



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Name:

Address:

List individuals who you would like involved in your care.

By writing their names on this form, you consent to the release of your health information to them.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above.

CONSENT I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information.

Signature: _____ Date: _____

If this Consent is signed by a personal representative / guardian on behalf of the patient, complete the following: Personal Representative's Name: _____
Date: _____ Relationship to Patient _____

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.